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Department of Health and Family Services

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MEMORANDUM

DATE: April 12, 2002

TO: COP County Contacts
Waiver County Contacts

FROM: Janice Smith, Assistant Director
Bureau of Aging and Long Term Care Resources

RE: Use of COP and Waiver Funds in CBRFs

A Division of Supportive Living memo #2002-02 was recently distributed which discusses recent statutory changes in the use of COP, COP-W and CIP II funds in CBRFs as well as implementation of the five conditions for funding CBRFs. This memo provides the following technical assistance information to assist in the implementation of the requirements.

- **Use of COP & Waiver Funds in CBRFs: Questions and Answers**

The attached Q&A document provides answers to typically asked questions in relation to the five conditions for funding as well as variance approval processes and other implementation highlights. As additional questions arise, another question and answer document may be issued if necessary.

- **Implementation of Five Conditions for Use of Funds in CBRFs-Model Forms**

Included in the attached material is a document that offers model forms that care managers can use to validate that the five conditions for funding are being met when placing an individual in a CBRF of any size. These model forms can be accessed electronically on the Department of Health and Family Services web-site at www.dhfs.state.wi.us/LTC_COP/modelforms.htm

- **Educational Teleconference Network (ETN) Training**

The Bureau will hold an informational session to discuss the policies referenced in DSL memo series 2002-02. The session will be held on May 15, 2002 from 10:00am to 11:50am. Please check the following website for further information: www.dhfs.state.wi.us/aging/training.htm.

In addition, as stated in the memo, a workgroup of providers, advocates, and county staff will be assisting the Department in developing a policy for the use of COP/Waiver funds in CBRFs with more than 20 beds. For your information, a directory of the workgroup members is attached.

If you have any questions or suggestions related to the attached material, feel free to contact Carrie Molke, BALTCR. If you have any questions about the implementation of these policies or any other COP or Waiver policy, please do not hesitate to call any of us in BALTCR's Long Term Support Section or your Assistant Area Administrator.

Attachments

Cc: Assistant Area Administrators-Adult Services
The Management Group

NUMBER: 151
April 12, 2002

INFORMATION community options program

USE OF COP & COP-W/CIP-II FUNDING IN CBRFS

Attached are technical assistance documents that can be used to assist Long Term Support Lead Agencies in implementing statutes and DSL memo series 2002-02 related to use of funding in CBRFs.

- DSL Memo Series 2002-02, The Infeasibility of Home-Care, Quality of the Facility and Services, Client Preference, Cost-effectiveness, The Pre-Admission Assessment & CBRF Size: Questions and Answers.

- Five Conditions on Use of Funds in CBRFs: Model Forms

These materials are available on the Department of Health and Family Services' web-site at www.dhfs.state.wi.us/LTC_COP/modelforms.htm. For further assistance, please contact Carrie Molke at the Bureau of Aging and Long Term Care Resources at *molkeca@dhfs.state.wi.us* or via telephone at 608-267-5267.

MEMO SERIES 2002-02
THE INFEASIBILITY OF HOME CARE, QUALITY OF THE FACILITY AND ITS SERVICES, CLIENT PREFERENCE, COST-EFFECTIVENESS, THE PRE-ADMISSION ASSESSMENT & CBRF SIZE

QUESTION AND ANSWERS

Determination that Home-care is Infeasible:

1. **Q**: What are the state's expectations in a situation where the applicant moves to a CBRF, exhausts their assets, and then seeks state long-term support funding, is it to be denied and this person forced to relocate if it is determined that home-care is feasible?

   A: If home-care is determined to be feasible for an applicant that has been residing in a CBRF or other substitute care setting, COP & Waiver funding is not allowed to be used to support that person in a CBRF. If the person chooses to reside in a home-care setting, or an Adult Family Home, or Residential Care Apartment Complex, etc., funding can be used.

2. **Q**: What if home-care is feasible, but the participant (or the participant's family) does not want to remain in their home?

   A: If home-care is feasible and a safe care plan can be put in place, in order to use this funding, they cannot be served in a CBRF. The statutes say that all of the conditions must be met, so that, even though the person prefers to live in a substitute care setting, home-care is feasible so funding cannot be used in a CBRF. Remember that these are conditions on the use of funding in CBRFs….not apartments or Adult Family Homes or Residential Care Apartment Complexes. If the person is adamant about not living at home, using this funding in other settings besides CBRFs can be explored.

Determination of Quality Environment and Services:

1. **Q:** Doesn't a state license attest to the quality care and environment of a facility?

   A: As stated in the memo, when purchasing services for an individual using public funding, it is a county's obligation to arrange and purchase quality services in a quality environment for consumers. People who are elderly, have a form of irreversible dementia, or have a disability have individualized needs that are not always addressed specifically for these populations in the licensing standards. There is a need, therefore, for individualized expectations of quality beyond licensing standards that address the specific needs of these individuals when using the funds that support them.

2. **Q:** Are there any examples of quality criteria that counties have already created and incorporated into their contract that other counties can use as examples?

   A: Yes. There are several counties that have incorporated quality standards into their contracts. BALTCR is in the process of obtaining examples for dissemination upon request.

3. **Q:** I don't want to be in a position of regulating facilities, isn't that what this really is?

   A: It is not our expectation that you be in a position of regulating facilities, that is the State's job through the Bureau of Quality Assurance. However, our expectation is that counties are purchasing services that meet county expectations and ensuring that participants are receiving quality services. Building quality standards into your contracts establishes an agreement between parties, outlines your expectations, and provides a basis for nullifying a contract that is not meeting a county or consumer standard.

4. **Q:** What if a CBRF does not comply with the quality standards I incorporate into the contracts?

   A: It will be important to build language related to non-compliance and monitoring into the contracts. Examples of this includes: terminating/suspending contract due to deficiencies, or withholding payments. You may want to say that the facility shall be monitored using the quality indicators you create, in that, you will be using these standards to evaluate the services the facility is providing to participants.

Determination of Client Preference:

1. **Q:** What happens if the individual and their family do not want to look at other alternatives?

   A: The policy states that an individual shall have the opportunity to visit one or more CBRFs, and, when desired, other residential settings. If they choose not to visit other facilities, so long as they have had the opportunity to do so, this requirement is met.

2. **Q:** What if there are no private room options in our county?

   A: If there are no private room options in your county, offer this option in another county. In addition, you may want to develop Adult Family Home options in your county where the individual can be offered a private room. The CBRF industry, as it continues to develop, is moving toward private room facilities. When it's practical, work with developers in your area to expand this as a resource in your county.

3. **Q:** What if an individual prefers a private room, but the cost is too great?

   A: Preference is only one criteria that must be met, cost-effectiveness is another. If a facility is not cost-effective, even though it is the person's preference, funding cannot be used in that CBRF. However, private rooms will simply cost more than shared rooms. Remember that cost-effectiveness should be determined in terms of comparable options that meet the "outcomes" of the person. For some, a private room in a CBRF is not comparable to a shared room or their personal goals and preferences cannot be met in a shared room environment. It is expected that this be considered when determining cost effectiveness.

4. **Q:** What if our county has a policy that says that they will not fund private rooms?

   A: A county that currently has a policy that they will not fund private rooms, will need to change their policy to comply with this new requirement. A county is not required to fund private rooms in order for participants to reside in CBRFs using this funding, however, they are required to offer the option.

Determination of Cost-Effectiveness:

1. **Q:** Does this mean that COP/COP-W/CIP-II funding can only be used in the cheapest residence?

   A: No. Cost-effective does not mean the cheapest or least expensive. It does mean that all of the consumers needs can be met at a cost that is reasonable in comparison with other community and nursing home alternatives. So that, if a person's outcomes can be met equally by the CBRF and home-care arrangements and the CBRF costs more, then the CBRF does not meet the cost-effectiveness test. Futhermore, if the CBRF can better meet the persons individualized needs at a higher cost than home care arrangements, then funding is allowable in the CBRF.

2. **Q:** What if home-care is less expensive, but the person prefers to reside in the CBRF?

   A: You will need to do a cost comparison between the cost of in-home care and care in a CBRF when the person prefers it. Again, cost-effective does not mean least expensive. As stated above, if the CBRF can better meet the persons individualized needs at a higher cost than home-care, then funding is allowable.

3. **Q:** What if a CBRF is less expensive than home-care, but home-care has been determined to be feasible and the person prefers to live at home?

   A: It is important to remember that these criteria must be met before funding can be used in a CBRF. If other community or home-care settings are preferred, these conditions do not need to be met. In other words, if home-care is preferred and

feasible, even though the CBRF costs less, the individual should be supported in their home.

4. **Q:** What if the CBRF is NOT cost-effective, but is preferred by the resident/guardian?

   A: As in several other variations to a similar question, funding cannot be used to support the individual in the CBRF since all five conditions must be met.

Pre-admission assessment

1. **Q**: If the person using COP funding was admitted to a CBRF prior to the county's implementation of the pre-admission assessment and is now eligible for waiver, are they not eligible for waiver funding because they did not have a pre-admission assessment?

   A: It is not necessary for an individual to receive a pre-admission assessment or consultation prior to the county's implementation of the requirement. For example, if an individual has resided in a facility since December of 1997 and the county implemented their pre-admission assessment in January 1998, they do not need to have had a pre-admission assessment/consultation for use of COP or Waiver funding. Even though the use of Waiver funding is not being used until 2002, the individual's admission to the facility was prior to the implementation of the pre-admission assessment/consultation requirement.

2. **Q:** What if a person is coming from another state, what are the expectations?

   A: It is not expected that you or your staff travel to other states to assess someone who is looking at moving to a CBRF. However, it is expected that they receive a pre-admission assessment in order to use COP/Waiver funding. The statute does not provide for much flexibility on this. If the person does not receive one, they will not be eligible for funding in that facility. What you may want to do is contact the CBRFs in your county letting them know your expectations. If the facility has an inquiry from someone who is from another state, let them know that it is critical for potential residents to contact you. Maybe a coordinated visit to the facility and the county can occur when the prospective resident is in the area. Both the pre-admission assessment and pre-admission consultation must be conducted face to face. Families need to be informed that if they want to be eligible for public funding in the future, contacting the county is necessary.

3. **Q:** If a person receives a pre-admission assessment or consultation prior to moving to CBRF A and then moves to CBRF B, do they need to receive another pre-admission assessment/consultation?

   A: So long as the individual has received a pre-admission assessment at any point

prior to admission to a CBRF, it doesn't matter when it was conducted or where the person resided at the time. You may have people that decide not to leave their home, for instance, after receiving a pre-admission assessment. If their needs change two years down the road and they decide to move into a CBRF then, they do not need another pre-admission assessment because they already received one previously. If CBRF A and CBRF B are in different counties, it is "best practice" to offer another assessment to inform the individual of different options in the other county. In fact, in this type of situation it is strongly encouraged since the new county's policies on CBRF use may be different. If the facility is in the same county and the information has changed, it is also considered "best practice" to offer another to update the individual on the changes that may effect them.

4. **Q:** What are CBRFs required to do, what is their obligation?

   A: State statutes (50.035 (9)) says that "every community-based residential facility shall **inform** all prospective residents of the assessment requirements under…[the pre-admission assessment section in the COP/COP-W/CIP-II statutes]….for the receipt of funds under those sections." Additionally, the Department is currently revising HFS 83 which will include this requirement.

5. **Q:** If a private pay person contacts the county for an assessment, decides to move into a CBRF after the assessment/consultation, and has sufficient funds to pay for his/her care for three years, for example, does another assessment need to be conducted when they run out of money in order to meet this requirement?

   A: No, not to meet this requirement. The key to this requirement is prior to admission. However, you will need to do an assessment and care plan when the person is eligible for funding.

6. **Q:** If a person didn't receive a pre-admission assessment before admission to a particular CBRF, are they ineligible for funding in all CBRFs, or only that one?

   A: They are only ineligible for funding in that CBRF for as long as they are a resident there. If they receive a pre-admission assessment prior to moving to another CBRF, they may be eligible to receive funding there. In other words, it does not mean that they are ineligible to receive COP/Waiver funding…they are just ineligible in that setting.

7. **Q:** If a person resided in a CBRF between the time that the county implemented the pre-admission assessment and May 1, 2002, (the date that the other four conditions must be met), do they have to meet the other four conditions to maintain their funding?

   A: No. Only individuals who seek funding, or become eligible for funding in CBRFs after May 1st, 2002, must meet the additional four criteria at the time of development of their care plan.

9. **Q:** What if a person is admitted to a facility for respite, and a pre-admission assessment has not been conducted, and the respite placement lasts longer than 28 days? Are they not eligible for funding in the facility if they decide to move there "permanently"?

   A: Since the pre-admission assessment is intended to inform prospective residents of long-term care options, the Department has determined that if a person was admitted for respite, this assessment is not required because it is not considered a long-term care placement. However, the county can define what they will do in these situations if they so choose. Respite, as defined in HFS 83 is 28 days. If the stay is longer than 28 days, it is not considered respite and a pre-admission assessment would have been required in order to receive funding in the facility if it, in fact, becomes a long-term placement. Counties should communicate with the CBRFs in their counties regarding their own policies for respite placements. Several counties do not exempt respite placements from the pre-admission assessment to avoid any confusion on the part of the facility and county regarding when an assessment needs to be done. Others do not, and find that many CBRFs contact them after admission and tell them that the individual was admitted as respite, but now wants to stay there on a long-term basis. Some facilities have actual admission agreements for respite, others do not. Again, communicate with the facilities in your county and lay out your expectations.

Questions related to CBRF size

1. **Q:** I'm confused….when a facility is larger than 20 beds, when do I need a variance from the Department?

   A: In almost all cases, a variance will be required. However, variances will only be approved under very limited circumstances. First, there are basically two situations when a variance is not needed: (1) if the facility consists of independent apartments or (2) if the person is a conversion from COP-Regular in the CBRF to the Waivers (the latter will only be pertinent for the first months of 2002). Second, please refer to the memo for information regarding the criteria that must be met in order for a variance to be approved. Variance requests should only be sent to the Department if one of the criteria is met.

2. **Q:** What if I need to place someone in a CBRF with more than 20 beds immediately?

   A: BALTCR will respond to variance requests within 15 working days. We will do all that we can to respond as quickly as possible to each request. However, the only allowable conditions for COP or COP-W/CIP II funding is described in the numbered memo. In almost all instances, the county will not be able to use these funding sources in large CBRFs. If a county still chooses to serve the person in an over 20 bed CBRF, it will have to find other funding to do so.

3. **Q:** Can a county have a policy that they won't use COP or Waiver funding in CBRFs with more than 8 beds…or more than 20?

   A: Yes. State Statutes (46.27(7)(ck), 46.27(11)(c)5p.& 46.277(5)(d)1p.) and the COP Guidelines (Section 3.01 B. 20.) state that "a county may establish and implement more restrictive conditions on the use of funds…for the provision of services to a person in a CBRF. A county that establishes more restrictive conditions…shall include the conditions in its community options plan."

Waiver Mandate: Conversions from COP-R to COP-W

1. **Q**: If the person has always been on COP-Regular in a CBRF, and due to this change, is now eligible for COP-W, what do care managers need to submit to The Management Group (TMG)?

   A: In most instances counties should treat these cases as similar to a new waiver application. Counties will not be reimbursed for a new assessment for these conversions and therefore may use existing assessment information. However, care managers should review and update the assessment and narrative to ensure that the information is current. All other information submitted, including the Health Form, the Functional Screen, and the financial eligibility information, must be current as well. No participant may have a start date prior to September 1, 2001.

2. **Q:** What if the participant was on Waiver, then went to COP because they moved to an ineligible CBRF, and are now waiver eligible again due to this change?

   A: If, during calendar year 2001, the participant left the waiver program for a COP funded setting that is now waiver eligible, the care manager does not need to send new application information to TMG. Instead, they should notify TMG that the participant is once again waiver eligible. TMG will send an updated approval letter. The re-certification date will remain the same as it was prior to the move. For example, the participant was newly approved for COP-W in February 2001, then moves to a non-waiver eligible setting the following May. Now, because of the change in statute, that setting has become waiver allowable, effective September 1, 2001. The county notifies TMG that that participant is again waiver eligible. TMG sends an updated approval letter indicating the participant's re-certification is due in February 2002.

3. **Q**: If the participant was on the Waiver program, then moved to an ineligible CBRF and went off the program during which time, if they were still on the waiver, a re-certification would be due, what do counties need to submit to TMG now that the setting is waiver allowable?

   A: The county needs to send in all new information (an assessment,

narrative/addendum, ISP, health form, Functional Screen and financial information). The participant would also get a new start date. This is necessary because Waiver functional and financial eligibility must be done annually. For example, a participant was on the waiver and re-certified in August, 2000 and then went off the program when they moved to an 18-bed CBRF in May, 2001. Now that setting is waiver allowable. Since the person would have been due for annual waiver re-certification in August, 2001, and it was not done because they were no longer on the program, care managers need to submit a new packet for this individual.

4. **Q**: If the person is residing in a CBRF with more than 20 beds using COP-Regular, does a variance need to be approved before I can convert them to the COP-W?

   A: No. Since these individuals have been receiving COP-Regular, it is likely that a variance has been approved for these funds due to grandfathering provisions. These provisions said that if a person resides in a CBRF that was licensed prior to July 1, 1995 or the individual resided in a facility prior to January 1, 1996 they may be eligible for COP funding. The Department has adopted these COP-Regular criteria for COP-W/CIP-II and therefore another variance does not need to be sought. However, if the person residing in a CBRF with more than 20 beds that was licensed before July 29th, 1995 has <u>not</u> been receiving COP funding (is a new applicant), a variance must be sought.

   To assist TMG in this process, please include a note that the person you are sending the Waiver packet for was receiving COP in the facility and that this is a conversion. By doing so, TMG will not have to wait for a variance approval.

5. **Q**: Will the department take a disallowance if the county takes longer than the typical allotted time to convert people from COP to the Waiver?

   A: No. However, since the reduction in COP-Regular funding was taken as of January, 2002, counties are encouraged to do this as quickly as possible. It is understood that some counties have several people to convert, and others don't have any. Conversions need to be completed within a timeframe that is reasonable given the caseload.

Model Forms

Five Requirements for CBRF placement

Pre-Admission Assessment/Consultation
Infeasibility of In-Home Services
Consumer Preference
Quality Services & Environment
Cost-Effectiveness

Prepared by Carrie Molke, Long Term Support Residential Policy Specialist
Bureau of Aging and Long Term Care Resources

Checklist of Five Conditions for the Use of Funding in CBRFs

Name of Applicant/Participant: _____ Date: _____

Directions: Check all of the following that are true. Attach relevant documentation.

Pre-admission Assessment/Consultation

- ❑ A pre-admission assessment was performed on _____. ***OR***
  Insert date
- ❑ A pre-admission consultation (where a county waives the assessment) was performed on _____.
  Insert date
- ❑ The individual was admitted to _____ CBRF on _____.
  Insert facility name Insert date

Infeasibility of In-Home Services

- ❑ It has been documented, in accordance with HFS 73.11 that in-home services are not feasible. Documentation is attached.

Client Preference

- ❑ An exploration of applicant/participant's lifestyle preferences has been performed.
- ❑ The individual has been offered a private room.
- ❑ The individual has been informed of all residential options.
- ❑ The individual has had the opportunity to visit other facilities of their choice.

Quality Care Services in a Quality Environment

- ❑ County established quality standards have been incorporated or attached to the contract with the facility.
- ❑ County has determined that the facility can meet the unique needs of the participant considering residence.

Cost Effective

- ❑ The functional screen, COP assessment and care plan are in the applicant's file.
- ❑ CBRF services and their costs have been calculated.
- ❑ Community care cost, including nursing home and home-care costs have been calculated.
- ❑ A cost comparison shows that the facility has the capacity to effectively meet the needs of the consumer at a reasonable cost.

Determination of the Infeasibility of In-Home Services

Completion of this form satisfies the requirement under HFS 73.11

Part I: A Change has Occurred & More Services are Required

A change has occurred for the individual in at least one of the following ways (check & describe):

- ❑ Condition: _____
- ❑ Functioning: _____
- ❑ Living situation: _____
- ❑ Supports: _____
- ❑ Other: _____

Arrangements that were in place and adequate to maintain the individual's health, safety and well being before the above change occurred, are no longer sufficient to provide or ensure the provision of what the individual needs.

❑ True ❑ False

Part II: In-home Service Options Explored

The following options for supporting the individual in their own home have been explored, and have failed or been found to be unavailable or not possible. (Further space available on following page.)

Option Explored	Reason unavailable or not possible

Part III: Declaration that In-Home Care is Infeasible

In order for home-care to be determined infeasible, Part I must indicate that a change has occurred which no longer provides or ensures what the individual needs & Part II above must indicate that in-home care options have been explored and are not available or possible.

Part I & Part II above indicate that in-home care is: ❑ Infeasible ❑ Feasible

_____ _____

LTS lead agency Representative Signature Date Applicant/Guardian Signature Date

Option Explored	Reason Unavailable or Not Possible

Determination of Client Preference

Part I: Lifestyle Preferences Explored

The following preferences were explored, and the individual prefers those checked below:

❑ A private room	vs.	❑ Sharing a room
❑ Rural setting	vs.	❑ Urban setting
❑ A house	vs.	❑ An apartment
❑ Small community	vs.	❑ Large community
❑ Social atmosphere	vs.	❑ Quiet atmosphere
❑ Men or woman only	vs.	❑ Mixed gender
❑ People their age	vs.	❑ Mixed age
❑ Small setting	vs.	❑ Large setting
❑ Other: _____	vs.	❑ _____
❑ Other: _____	vs.	❑ _____
❑ Other: _____	vs.	❑ _____

Note: For those unable to express their preferences, due to cognitive limitations or an inability to communicate, an exploration has been made to determine what their most likely choices and preferences would be based on reports from family, friends, or others who have known them a long time.

Part II: Option of a Private Room

If the individual resides or intends to reside in a CBRF with more than eight beds, the individual has been offered a private bedroom at the following facility:

_____ _____
Facility Name Facility type (i.e., CBRF, RCAC, AFH)

Part III: Information and Visitation of Residential Options

The individual has been fully informed of all of the following residential options, and the advantages and disadvantages of each:

Supports in their own home/apartment:	_____ Yes	_____ No
Adult Family Home	_____ Yes	_____ No
Residential Care Apartment Complex (RCAC)	_____ Yes	_____ No
A CBRF with Independent Apartments	_____ Yes	_____ No
A small CBRF (5-8 beds)	_____ Yes	_____ No
A medium CBRF (9-20 beds)	_____ Yes	_____ No
A large CBRF (21+ beds)	_____ Yes	_____ No
A Nursing Home	_____ Yes	_____ No

Residential options presented to applicant and/or the guardian, when available, consider lifestyle preferences as determined in Part I above.

The individual has had the opportunity to visit the following facilities:

Facility Name	Facility type (i.e., CBRF, RCAC, AFH)
Facility Name	Facility type (i.e., CBRF, RCAC, AFH)
Facility Name	Facility type (i.e., CBRF, RCAC, AFH)
Facility Name	Facility type (i.e., CBRF, RCAC, AFH)

Part IV: Declaration of Client Preference

The facility that is preferred is _____.
Facility Name

Applicant /Guardian Signature	Date	County Representative Signature	Date

Determination that CBRF is Cost-Effective

Part I: Documentation Required in Applicant's File

The following documentation is in the program applicant's file:

- ❑ Functional Screen
- ❑ Complete Community Options Program Assessment
- ❑ Care Plan

Part II: Projected Community Care Costs

The following chart lists the average total service costs of feasible community services, provided in home or in other residential settings, that meet identified needs of the individual.

Community Services (when feasible)	Average Total Service Costs
***Comparable In-home Services	***$
Comparable Adult Family Home Services	$
Comparable RCAC services	$
Comparable CBRF with Independent Apartments	$
***Comparable Nursing Home Services	***$
Other Comparable Options	$

***This calculation is required.

Part III: Cost Comparison

The total cost of _____CBRF for _____ is $_____.
Facility Name Applicant Name

Compare the costs of the chosen CBRF to the costs listed in Part II.

Part IV: Declaration of Cost Effectiveness

The cost comparison shows that the facility has the capacity to effectively meet the needs of the consumer at a reasonable cost.

☐ True ☐ False

_____ _____
Applicant/Guardian Signature Date County Representative Date

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